

Committee to Study the Disparity in Reimbursement among Organizations that Provide Case Management under Social Security Act Section 1915(c) Waiver Programs

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Ms. Cooper will address the following questions with the Committee:

Medicaid and Case Management for People with Developmental Disabilities: Structure, Practice, and Issues

National Association of State Directors of Developmental Disabilities Services - NASDDDS April 2019

- **Is there a federal regulation for case management for HCBS?**

Yes—the Medicaid admin, TCM and waiver regulations apply if you want to use Medicaid

**Home and Community Based Services (HCBS) waiver
Core services definition waiver technical guide, p.105**

- Evaluation and/or re-evaluation of level of care;
- Assessment and/or reassessment of the need for waiver services;
- Development and/or review of the service plan;
- Coordination of multiple services and/or among multiple providers;
- Linking waiver participants to other federal, state, and local programs;
- Monitoring the implementation of the service plan and participant health and welfare,
- Addressing problems in service provision;
- Responding to participant crises; and
- For waivers with cost or service duration limits, monitoring to detect and resolve situations when the needs of an individual might exceed the limit(s) to ensure health and welfare of waiver participants

**Targeted Case Management (TCM)
42 CFR §440.169.**

- D. The assistance that case managers provide in assisting eligible individuals obtain services includes -
1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services. These assessment activities include the following:
 - i. Taking client history.
 - ii. Identifying the needs of the individual, and completing related documentation.

- iii. Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the eligible individual.
2. Development (and periodic revision) of a specific care plan based on the information collected through the assessment, that includes the following:
 - i. Specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.
 - ii. Includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals.
 - iii. Identifies a course of action to respond to the assessed needs of the eligible individual.
3. Referral and related activities.
4. Monitoring and follow-up activities.
5. Assuring:
 - i. Services are being furnished in accordance with the individual's care plan.
 - ii. Services in the care plan are adequate.
 - iii. There are changes in the needs or status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.
6. Case management may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.¹

Administrative Case Management

42 CFR §433.15(b)(7)

Medicaid administrative activities refer to those costs that are "as found necessary by the Secretary for the proper and efficient administration of the state plan."² The Secretary of Health and Human Services has final determination of which activities are allowable. In addition to case management activities, some common activities that fall under administrative claiming include:

- Medicaid eligibility determination,
 - Medicaid intake processing,
 - the prior authorization of Medicaid services (to the extent that a state requires this activity to be conducted in advance of furnishing a service),
 - preadmission screening or level of care evaluations for persons being admitted to an institutional setting,
 - Medicaid outreach activities, and
- the day-by-day costs incurred in operating the state Medicaid agency (SMA).³

¹ Excerpts from: 42 CFR §440.169.

² 42 CFR §433.15(b)(7).

³ See www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD122094.pdf.

- **What is the best practice for a scope of services or governance for case management for HCBS?**

The activities should reflect two spheres—the individual supports, outcome and quality and system monitoring

Agent of the person but also an agent of the “state”—carrying out state policies and practices that improve the lives of the individuals serviced

- **Does case management need to, or should it be, the same across all HCBS waivers? Is this defined in federal regulation?**

Not required nor defined I state regulation—and there is no requirement that CM be the same, particularly the qualifications.

Case managers supporting seniors need different skill and knowledge to perform their job say from CMs serving adult with ASD and criminal justice involvement! May have a basic set of core competencies with disability-specific skill sets

- **Is case management typically billed at a monthly, daily, or other unit?
Monthly and 15 minutes**

From Medicaid and Case Management monograph

DD case management 47 states responding

TIME	TC M	HCBS Waiver	1115	Admin	(b)/(c)
5 minute	2	0	0	0	0
15 minute	10	3	0	0	1
Hourly	0	1	1	0	0
Daily	0	0	0	0	0
Weekly	1	2	0	0	0
Monthly	8	13	0	0	1
Fixed Fee Contract	0	0	0	1	0
Other	2	2	1	5	1

- **Does 24/7, 365 support belong with the Organized Health Care Delivery System (OHCDS), Case Management, or can it be done by either?**

If you mean that the A is a reasonable place for 24/7 on-call responsibility, that might be okay. In this sense they act as a safety net and are for example the entity responsible for tracking abuse or are the authorizing agency for emergency services...24/7 responsibility would be defined in the scope of duties and compensated accordingly on a Medicaid admin cost allocation plan

24/7 is also typically a case management agency/provider requirement as well—individual should be able to access their case manager in an emergency—but if you do not want this, then there must be a very clear and well-defined and well-understood point of contact in an emergency...This means, families, individuals, providers, --and this may mean more than one contact point, say A and CM agency